

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-011158

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

FILED APR 2 1962

Primary Registration District No. 1002

Registrar's No.

1567

VS 300
Rev. 4/59

DATE AMENDED

INSTEAD OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|--|--------------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY JACKSON b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5837 COLLEGE STREET | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON c. CITY OR TOWN KANSAS CITY d. STREET ADDRESS 5837 COLLEGE STREET | |
| 3. NAME OF DECEASED (Type or print) First Middle Last CHARLES C. McBRIDE | | 4. DATE OF DEATH Month Day Year MARCH 16th 1962 | |
| 5. SEX MALE | 6. COLOR OR RACE CAUCASIAN | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 2-25-88 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRICKMASON SUPERINTENDANT SWENSON CONST. CO. MOUNT ROSE MO. U.S.A. | | 11. BIRTHPLACE (City and state or country) MOUNT ROSE MO. U.S.A. | |
| 13a. FATHER'S NAME THOMAS. FELDING. McBRIDE | | 13b. MOTHER'S MAIDEN NAME BELLE ZORA GREGG | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NONE | | 16. SOCIAL SECURITY NO. [REDACTED] | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, generalized Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | 14. NAME OF HUSBAND OR WIFE ELSIE. MAY. McBRIDE | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21. I attended the deceased from 11-13-59 to 3-16-62 and last saw her alive on 3-16-62 Death occurred at 9.30 P m on the date stated above, and to the best of my knowledge, from the causes stated. | | 22. ADDRESS 7951 State Line | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE Mch. 19, 1962 | |
| 23c. NAME OF CEMETERY OR CREMATORY MT. MORIAH CEMETERY | | 23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI | |
| 24. FUNERAL DIRECTOR D.W. Newcomer's Sons Kansas City Mo | | 25. DATE RECD. BY LOCAL REG. 3-19-62 | |
| 26. REGISTRAR'S SIGNATURE Ruth Long | | 27. DATE SIGNED 3/17/62 | |

USE BLACK INK
OR
TYPEWRITER RIBBON

DR. WALTER D. STELMACH
7951 STATE AVE
H.I. 4-7367. 20 2:30

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Walter D. Stelmach

Licensed Embalmer No. 4889

P. O. Address

Lithia, Me.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.